REMARKS

Reconsideration of the present patent application is respectfully requested.

In the Office Action of December 24, 2008, the Examiner rejects claims 1 and 3 under 35 USC §112, second paragraph. Claim 1 has been amended as set forth above to state that the policy is a state-governed fully-insured health insurance policy, obviating any concerns raised by the Examiner as to what policy is at issue. Claim 3 has been amended to state that the tax-deductible expense is a tax-deductible expense to the employer. This amendment should remove any confusion as to whom the expense is tax-deductible. Withdrawal of the rejections under 35 USC §112, second paragraph, is therefore respectfully requested.

Claims 1 and 15 are rejected under 35 USC §101 as being directed to non-statutory subject matter. Applicant disagrees. The Examiner bases his conclusion on an alleged failure of claims 1 and 15 to satisfy the "machine or transformation" test articulated in item number 3 of the subject Office Action. The Examiner also states that for a claimed invention to be statutory subject matter eligible, the claimed invention must fall within a judicial exception. Applicant respectfully submits that the Examiner misstates the law. The "judicial exceptions" to which the Examiner refers are examples of non-statutory subject matter, such as abstract ideas, laws of nature and natural phenomena. Thus, rather than needing to satisfy a judicial exception to be statutory subject matter eligible, as asserted by the Examiner, judicial exceptions are in fact examples of non-statutory subject matter. The Examiner appears to find that claims 1 and 15 recite abstract ideas only, and Applicant thus presumes that the Examiner intended to argue that claims 1 and 15 involve subject matter which is a "judicial exception." However, even if such a conclusion is merited, which it is not, this does not end the inquiry required by the MPEP for ascertaining compliance with 35 USC §101.

It is incumbent upon the Examiner to determine whether a claimed invention covers either a 35 USC §101 judicial exception or a practical application of a 35 USC §101 judicial exception. MPEP §2106. The conclusion that a particular claim includes a 35 USC §101 judicial exception does not end the inquiry because the practical application of a judicial exception may qualify for patent protection. In other words, to establish a prima facie case of non-statutory subject matter under 35 USC §101, the Examiner must first determine whether the claimed invention represents a judicial exception, and then must determine whether the claimed invention is a practical application of a 35 USC §101 judicial exception. MPEP §2106 is quite clear that the patent examiner must determine whether the claimed invention which is purportedly within a judicial exception produces a useful, concrete and tangible result. Each of these factors are to be considered and weighed by the Examiner. The Examiner is then to determine whether the claimed invention preempts a 35 USC §101 judicial exception. It is only by performing the factual analysis prescribed by the MPEP that the Examiner can establish a prima facie

case of non-statutory subject matter. In particular, the Examiner must weigh the determinations as to useful, concrete and tangible results to reach a conclusion as to whether it is more likely than not that the claimed invention as a whole either falls outside of one of the enumerated statutory classes or within one of the exceptions to statutory subject matter. This burden is initially upon the Examiner, and it is only after presenting a prima facie case that the burden shifts to Applicant. Absent factual analysis, as here, the Examiner has failed to even shift the burden to Applicant.

Applicant has reviewed and acknowledges the instructions to the Patent Examining Corps in the Memorandum dated January 7, 2009 which modify the guidelines set forth in MPEP §2106 for examining patent claims as to subject matter eligibility. Applicant respectfully submits, however, that nowhere in the subject Memorandum, or in any other source of authority, is the Examiner authorized to ignore the core requirements for establishing a prima facie case. While the rejections under 35 USC §101 would need to at least be supplemented to give Applicant a fair opportunity to respond, to expedite prosecution Applicant has nevertheless amended claim 1 to incorporate subject matter of claim 2 and has amended claim 15 to incorporate subject matter of claim 16. Neither of claims 2 nor 16 is rejected under 35 USC §101, and the rejections should therefore be withdrawn. If the Examiner is compelled to raise further subject matter eligibility issues, he is respectfully requested to adhere to the requirements of the MPEP. Surely, given that the state of the law as to subject matter eligibility is in flux, Applicant is entitled to a robust examination in keeping with the MPEP, and issues for appeal will be greatly simplified if the Examiner will adhere to the guidelines set forth therein.

Claims 1-4 and 6-9 are rejected under 35 USC §103(a) as being unpatentable over reference U in view of reference V. These rejections are traversed. The reasons for the traversal of the rejections are similar to those previously explained to the Examiner in prior Office Action Responses. Namely, the primary reference U does not teach the subject matter for which it is cited nor the subject matter of Applicant's claims, but only a federally-governed self-funded insurance strategy. Because the Examiner has persisted in this line of reasoning despite Applicant's previous explanations to the contrary, Applicant has now submitted evidence further supporting his position that the health insurance policies proposed or alluded to in Reference U are not in fact state-governed fully-insured health insurance policies, as further explained herein.

The term "state-governed fully-insured health insurance policy" has a specific meaning and refers to a health insurance product that is governed by state law, not ERISA, and where coverage according to an insurance contract is provided in exchange for premium payments paid at least partially by an employer. The Examiner's attention is respectfully drawn to the attached three-page excerpt from the Federal Register entitled Federal Regulations For Health Coverage Portability; Final Rule, dated Thursday, December 30, 2004 (hereinafter "Excerpt I"). Excerpt I states on page 2, middle column, that

for coverage supplemental to a group health plan to qualify as excepted benefits, the coverage must be specifically designed to fill gaps in primary coverage, such as co-insurance or deductibles. On page 3, right column, Excerpt I further states that supplemental benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance, and lists Medicare Supplemental Health Insurance, TRICARE Supplemental Programs, and similar supplemental coverage provided to coverage under a group health plan. In a second attachment hereto entitled Field Assistance Bulletin No. 2007-04, the United States Department of Labor explains that the provisions of ERISA and HIPAA do not apply to certain excepted benefits, and that where all of the benefits of a given plan are excepted benefits, then the plan and any health insurance coverage under the plan does not have to comply with the health reform requirements.

A corollary to these regulations, and ERISA itself, is that group health insurance plans and plan benefits which do not fall within enumerated exceptions, are federally-governed policies under ERISA. Thus, Applicant's claim term "state-governed fully-insured health insurance policy" by definition refers to a policy which is not governed by ERISA. And, the proposed amalgam of insurance coverage set forth in Reference U is by definition a policy which is governed by ERISA, since it does not fall within any of the enumerated exceptions. Reference U even recognizes at paragraph 3b, that ERISA would need to be modified to allow states to regulate the proposed "24-hour-coverage." Reference V does not cure this defect, as it too by definition only teaches plans which are governed by ERISA. As a matter of law, neither of the cited references teaches or suggests a state-governed fully-insured group health insurance policy, the proposed combination does not set forth a prima facie case, and the rejections to claims 1, 15, and the claims dependent thereto, should be withdrawn. Applicant further submits that the Examiner's position requires an interpretation of governing law which is different from that set forth by the Department of Labor. In other words, the Examiner argues that a plan which is federally-governed is actually state-governed. If the USPTO is authorized to interpret legislation/regulations differently from another Federal agency, the Examiner is invited to explain how this may be.

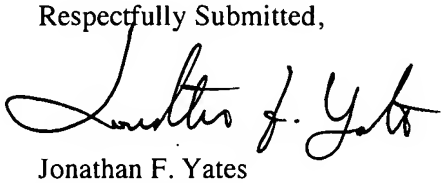
The Examiner's attention is also respectfully drawn to another attached document, which includes a two-page Federal Register Excerpt entitled Non-Discrimination And Wellness Programs In Health Coverage In The Group Market, Final Rules, dated Wednesday, December 13, 2006 (hereinafter "Excerpt II"). Excerpt II, on page 2, describes the conditions under which a benefit under a policy for an employee may be conditioned upon participation in a voluntary wellness program. Wellness programs which do not comply with the requirements articulated in the Excerpt, are impermissible in federally-governed plans. The Examiner points to Reference V as teaching conditioning a benefit under a state-governed fully-insured policy to participation in a voluntary wellness program. This position is also in error. Applicant acknowledges that page 18 of Reference V discusses establishing a wellness program, and suggests

rewarding employees for participation therein. Reference V, however, notes that employers choosing wellness programs should be aware that governing agencies issued proposed rules establishing "bona fide wellness plan" requirements for plans that apply discounts or surcharges tied to participation standards. The "bona fide wellness plans" to which Reference V refers are federally-governed plans explained at page 2 of Excerpt II. Thus, even if Reference V might be said to teach or suggest conditioning a benefit upon participation in a wellness program, no fair reading of Reference V can find that it teaches or suggests conditioning a benefit *under a state-governed fully-insured* policy. For these additional reasons, the rejections should be withdrawn.

Claims 15-20 are rejected under 35 USC §103(a) on the basis of Reference U in view of Reference V, and further in view of United States Patent Application Publication Number 2003/009355 to Gupta. These rejections should be withdrawn for reasons similar to those explained above with regard to claims 1 and 15. Namely, neither References U nor V teaches or suggests all that for which they are cited, and as a matter of law the proposed combination of references does not set forth a prima facie case under 35 USC §103(a).

All of the outstanding issues with regard to patentability of the pending claims are now believed resolved. If, however, Applicant may provide the Examiner any additional information or assist in the prosecution of the present patent application in any way the Examiner is invited to contact the undersigned attorney at (812) 333-5355.

Respectfully Submitted,



Jonathan F. Yates
Reg. No. 52,384

Federal Register

Wednesday,
December 13, 2006

Part III

Department of the Treasury

Internal Revenue Service
26 CFR Part 54

Department of Labor

Employee Benefits Security Administration
29 CFR Part 2590

Department of Health and Human Services

Centers for Medicare & Medicaid Services
45 CFR Part 146

Nondiscrimination and Wellness Programs in Health Coverage in the Group Market; Final Rules

section clarifies that the wellness program does not violate this section if participation in the program is made available to all similarly situated individuals. If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of paragraph (f)(2) of this section are met.

(1) *Wellness programs not subject to requirements.* If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate this section, if participation in the program is made available to all similarly situated individuals. Thus, for example, the following programs need not satisfy the requirements of paragraph (f)(2) of this section, if participation in the program is made available to all similarly situated individuals:

(i) A program that reimburses all or part of the cost for memberships in a fitness center.

(ii) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(iii) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.

(iv) A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.

(v) A program that provides a reward to employees for attending a monthly health education seminar.

(2) *Wellness programs subject to requirements.* If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of this paragraph (f)(2) are met.

(i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 20 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses or spouses and dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(2), the cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

(ii) The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of or preventing disease in participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(iii) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(iv) The reward under the program must be available to all similarly situated individuals.

(A) A reward is not available to all similarly situated individuals for a period unless the program allows—

(1) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(2) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(B) A plan or issuer may seek verification, such as a statement from an individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(v)(A) The plan or issuer must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under paragraph (f)(2)(iv) of this section. However, if plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.

(B) The following language, or substantially similar language, can be used to satisfy the requirement of this paragraph (f)(2)(v): "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward." In addition, other examples of language that would satisfy this requirement are set forth in *Examples 3, 4,* and *5* of paragraph (f)(3) of this section.

(3) *Examples.* The rules of paragraph (f)(2) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan. The annual premium for employee-only coverage is $3,600 (of which the employer pays $2,700 per year and the employee pays $900 per year). The annual premium for family coverage is $9,000 (of which the employer pays $4,500 per year and the employee pays $4,500 per year). The plan offers a wellness program with an annual premium rebate of $360. The program is available only to employees.

(ii) *Conclusion.* In this *Example 1,* the program satisfies the requirements of paragraph (f)(2)(i) of this section because the reward for the wellness program, $360, does not exceed 20 percent of the total annual cost of employee-only coverage, $720. ($3,600 × 20% = $720.) If any class of dependents is allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 20 percent of the cost of family coverage, $1,800. ($9,000 × 20% = $1,800.)

Example 2. (i) *Facts.* A group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) *Conclusion.* In this *Example 2,* the program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard or waive the cholesterol standard. (In addition, plan materials describing the program are required to disclose the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) for obtaining the premium discount. Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

Federal Register

Thursday,
December 30, 2004

Part III

Department of the Treasury

Internal Revenue Service

26 CFR Parts 54 and 602

Department of Labor

Employee Benefits Security Administration

29 CFR Part 2590

Department of Health and Human Services

Centers for Medicare & Medicaid Services

45 CFR Parts 144 and 146

Final Regulations for Health Coverage Portability; Final Rule

Notice of Proposed Rulemaking for Health Coverage Portability and Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV; Proposed Rules

generally be restricted by the employer or HSA trustee. Under the statute and administrative guidance, any expense incurred after an HSA is established is eligible for reimbursement, without restriction by an employer contributing to the HSA or trustee of the HSA. Thus, as a practical matter, whether or not an expense relates to a preexisting condition cannot determine the reimbursement. As such HSAs by design cannot impose a preexisting condition exclusion. Similarly, due to comparability rules requiring uniform contributions to HSAs by employers, employers and trustees generally cannot use differing amounts of contributions to impose a preexisting condition exclusion.

The eligibility for tax-free reimbursement from an HSA is also determined by statute; namely, the qualified medical expenses of the HSA owner and the HSA owner's dependents incurred after the HSA is established may be reimbursed on a tax-free basis by the HSA. Special enrollment rules for dependent children or spouses are not relevant because once an HSA is established they are eligible for tax-free reimbursements immediately. With respect to special enrollment upon loss of coverage, the rules for employer contributions generally require that all employees who are eligible for HSA contributions and participating in the employer's HDHP receive comparable HSA contributions. Thus, the combination of the comparability rules and the application of the special enrollment rules to the HDHP will generally ensure compliance with respect to employer HSA contributions because once an employee is enrolled in an employer-provided HDHP due to the special enrollment rules, the employer must make comparable contributions to the employee's HSA.

Indemnity Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, hospital indemnity and other fixed-dollar indemnity insurance are excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; if there is no coordination of benefits between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and if the benefits are paid with respect to an event regardless of whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. These regulations clarify that, for hospital indemnity or other fixed-dollar indemnity insurance to qualify as excepted benefits, such insurance must pay a fixed dollar amount per day (or other period), regardless of the amount of expenses incurred. An example clarifies that if a policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum amount per day, the benefits are not excepted benefits. This is the result even if, in practice, the policy pays the maximum for every day of hospitalization.

Supplemental Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act); coverage supplemental to TRICARE; and similar coverage that is supplemental to a group health plan are excepted benefits if they are provided under a separate policy, certificate, or contract of insurance. These regulations clarify that, for coverage supplemental to a group health plan to qualify as excepted benefits, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Coverage that becomes secondary or supplemental only under a coordination-of-benefits provision in the insurance contract or plan documents does not qualify as excepted supplemental benefits.

Treatment of Partnerships

Any plan, fund, or program that is established or maintained by a partnership and that provides medical care to present or former partners or their dependents, and that otherwise would not be an employee welfare benefit plan, is considered an employee welfare benefit plan that is a group health plan under Part 7 of ERISA and Title XXVII of the PHS Act.[10] As such, the partnership is considered the employer with respect to any partner. Participants in the plan include individuals who are partners of the partnership. Additionally, with respect to group health plans maintained by self-employed individuals (under which one or more employees are participants), the self-employed individual is considered a participant if this individual is or may become eligible to receive a benefit under the plan or if the individual's beneficiaries may be so eligible. These regulations clarify that, for purposes of Part 7 of ERISA and Title XXVII of PHS Act, a partner must be a bona fide partner in order to be considered an employee, and the partnership is considered the employer of a partner only if the partner is a bona fide partner. These final regulations also clarify that whether an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

Counting the Average Number of Employees

A paragraph has been reserved in the final rules for determining the average number of employees employed by an employer for a year. For proposed rules on this topic, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register.**

C. Economic Impact and Paperwork Burden

Summary—Department of Labor and Department of Health and Human Services

HIPAA's group market portability provisions, which include limitations on the scope and application of preexisting condition exclusions, and special enrollment rights, provide a minimum standard of protection designed to increase access to health coverage. The Departments crafted these final regulations to secure these protections, consistent with the intent of Congress, and to do so in a manner that is economically efficient.

The primary economic effects of HIPAA's portability provisions ensue directly from the statute. These regulations, by clarifying and securing HIPAA's statutory protections, will delineate and possibly expand HIPAA's effects at the margin.

Effects of the Statute

HIPAA's statutory group market portability provisions extend coverage to certain individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits. In some instances these individuals will gain coverage for services they otherwise would have purchased out-of-pocket. In other instances the extension of coverage will induce individuals to consume more (or different) health care services, which in some cases may improve health outcomes. The dollar value of the extended coverage is estimated to be $515 million annually. Potential additional benefits from improved health outcomes are difficult

[10] Such a plan, fund, or program is also considered a group health plan under section 5000(b)(1) and Chapter 100 of the Code.

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1), or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2)) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* (*See* 29 CFR 2590.732(d)(1) and 45 CFR 146.145(d)(1), under which a plan providing medical care, maintained by a partnership, and usually not treated as an employee welfare benefit plan under ERISA is treated as a group health plan for purposes of Part 7 of Subtitle B of Title I of ERISA and Title XXVII of the PHS Act.)

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

U.S. Department of Labor Employee Benefits Security Administration
Washington, D.C. 20210

FIELD ASSISTANCE BULLETIN NO. 2007-04

DATE: DECEMBER 7, 2007

MEMORANDUM FOR: VIRGINIA C. SMITH, DIRECTOR OF ENFORCEMENT
REGIONAL DIRECTORS

FROM: DANIEL J. MAGUIRE
DIRECTOR OF HEALTH PLAN STANDARDS AND COMPLIANCE ASSISTANCE

SUBJECT: SUPPLEMENTAL HEALTH INSURANCE COVERAGE AS EXCEPTED BENEFITS UNDER HIPAA AND RELATED LEGISLATION

ISSUE:

What are the circumstances under which supplemental health insurance coverage satisfies the requirements for excepted benefits under sections 732(c)(3) and 733(c)(4) of ERISA?

BACKGROUND:

HIPAA Health Reform and Related Legislation

Titles I and IV of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (HIPAA) amended the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (Code), and the Public Health Service Act (PHS Act) to improve portability, access, and continuity with respect to group health plan coverage provided in connection with employment. These laws include limitations on preexisting condition exclusions, require issuance of certificates of creditable coverage, provide special enrollment rights, and prohibit discrimination on the basis of any health factor. Later amendments to these laws provide protections relating to mental health parity, hospital lengths of stay following childbirth, and post-mastectomy coverage. Regulations issued by the Departments of Labor, the Treasury, and Health and Human Services (the Departments) on these group market provisions are contained in 29 CFR Part 2590, 26 CFR Part 54, and 45 CFR Parts 144 and 146. Additional reforms were provided in the PHS Act for health coverage in the individual market and are contained in 45 CFR Parts 144 and 148.

In general, these health reform provisions apply to group health plans (generally plans established or maintained by employers or employee organizations, or both) and health insurance issuers in the group or individual market. However, these provisions do not apply to certain excepted benefits. In general, if all benefits under a plan or coverage are

excepted benefits, then the plan and any health insurance coverage under the plan does not have to comply with the health reform requirements, and the coverage may not qualify as creditable coverage.

Supplemental Health Insurance Coverage

One category of excepted benefits is supplemental excepted benefits. Benefits are supplemental excepted benefits only if they are provided under a separate policy, certificate, or contract of insurance and are either Medicare supplemental health insurance, TRICARE supplemental programs, or similar supplemental coverage provided to coverage under a group health plan. The phrase "similar supplemental coverage provided to coverage under a group health plan" is not defined in the statute or regulations. However, the regulations clarify that one requirement to be similar supplemental coverage is that the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles (but similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision). 29 CFR 2590.732 (c)(5)(i)(C), 26 CFR 54.9831-1(c)(5)(i)(C), and 45 CFR 146.145(c)(5)(i)(C).

Coordination of Administration

Various situations have come to the attention of the Departments that raise concerns about whether all of the coverage that is being marketed as similar supplemental coverage actually qualifies as such.

Section 104 of HIPAA requires the Secretaries of Labor, the Treasury, and Health and Human Services to ensure that guidance under HIPAA issued by the Departments that relates to the same matter be administered so as to have the same effect at all times. In accordance with section 104 of HIPAA, each of the Departments is issuing guidance concerning the requirements for "similar supplemental coverage" that qualifies as benefits excepted from the requirements of HIPAA. The guidance being issued has been developed on a coordinated basis by the Departments. HHS is also issuing guidance on similar supplemental coverage for the individual market.

DISCUSSION:

In order to prevent issuers from avoiding compliance with ERISA's health reform provisions by issuing multiple insurance contracts in connection with a plan, this bulletin establishes an enforcement safe harbor under which supplemental health insurance will be considered excepted benefits for purposes of Part 7 of ERISA. Similar supplemental coverage that does not meet the standards for this safe harbor may be subject to enforcement actions by the Department.

To fall within the safe harbor, a policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan and must be specifically designed to fill gaps in primary coverage.

In addition, the Department believes that the value of the supplemental coverage must be significantly less than the value of the primary coverage that it supplements. To fall within the enforcement safe harbor, the cost of supplemental coverage may not exceed 15 percent of the cost of the plan's primary coverage. The Department will determine cost in the same manner as the "applicable premium" is calculated under a COBRA continuation provision.[1] Some plans subject to HIPAA titles I or IV are not subject to the COBRA continuation coverage requirements, such as plans maintained by an employer with 20 or fewer employees. For these plans, the Department will compute cost as if they were subject to COBRA. (For insured coverage -- all supplemental coverage and primary coverage to the extent insured -- the COBRA cost is, for purposes of this bulletin, the cost of the insurance coverage.)

Issuers of Medicare supplemental health insurance (commonly referred to as "Medigap") generally are subject to prohibitions against discrimination based on enrollees' or potential enrollees' health status. Accordingly, to fall within the enforcement safe harbor, the coverage may not differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual.

CONCLUSION:

For purposes of enforcing ERISA's health reform provisions, the Department will treat coverage as "similar supplemental coverage provided to coverage under a group health plan" under 29 CFR 2590.732(c)(5)(i)(C), within the enforcement safe harbor, if it is a separate policy, certificate, or contract of insurance and if it satisfies all of the following requirements:

(1) Independent of Primary Coverage. The supplemental policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan. For this purpose, entities that are part of the same controlled group of corporations or part of the same group of trades or businesses under common control, within the meaning of section 52(a) or (b) of the Code, are considered a single entity.

(2) Supplemental for Gaps in Primary Coverage. The supplemental policy, certificate, or contract of insurance must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination-of-benefits provision.

(3) Supplemental in Value of Coverage. The cost of coverage under the supplemental policy, certificate, or contract of insurance must not exceed 15 percent of the cost of primary coverage. Cost is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

[1] Under the COBRA rules, plans are generally permitted to charge up to 102 percent of the applicable premium. Thus, COBRA cost for purposes of this bulletin is 100 percent of the applicable premium, not 102 percent of the applicable premium that the plan is generally permitted to charge under the COBRA rules.

(4) Similar to Medicare Supplemental Coverage. The supplemental policy, certificate, or contract of insurance that is group health insurance coverage must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

Questions concerning the information contained in this Bulletin may be directed to the Office of Health Plan Standards and Compliance Assistance at 202-693-8335.